DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(3) DATE SURVEY COMPLETED	
		435118	B. WING			03/09/2022	
NAME OF PROVIDER OR SUPPLIER			1	ŞT	REET ADDRESS, CITY, STATE, ZIP CODE		
					1 SOUTH FIRST AVENUE		
PRAIRIE \	/IEW HEALTHCARE CEN	NTER		W	OONSOCKET, SD 57385		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	i	FC	000			
F 576	42 CFR Part 483, Sul Long Term Care facili 3/7/22 through 3/9/22 Center was found not following requirement	h survey for compliance with bpart B, requirements for ties, was conducted from the remarks are with the the response to the results and the results are the results are the results are r	F 5	576	No immediate corrective action c	ould	3/31/2022
	CFR(s): 483.10(g)(6)- §483.10(g)(6) The res reasonable access to including TTY and TD the facility where calls overheard. This includ use a cellular phone a expense. §483.10(g)(7) The fac facilitate that resident individuals and entitie facility, including reas (i) A telephone, includ (ii) The internet, to the facility; and (iii) Stationery, postag the ability to send ma §483.10(g)(8) The res and receive mail, and and other materials de resident through a me service, including the (i) Privacy of such cor with this section; and	sident has the right to have the use of a telephone, DD services, and a place in so can be made without being des the right to retain and at the resident's own cility must protect and 's right to communicate with as within and external to the conable access to: ding TTY and TDD services; a extent available to the ge, writing implements and it. sident has the right to send to receive letters, packages elivered to the facility for the cans other than a postal right to: mmunications consistent ary, postage, and writing			be taken for residents: 1, 4, 6, 7, 14 21, 22, 28 and 33. All residents recommil are at risk. 2. Administrator, Director of Nursing the Interdisciplinary Team have revithe Resident Mail Policy which incluthe timeliness of mail delivery. All st were educated on the mail delivery on 3/31/22. Staff not in attendance educated on mail delivery prior to the next working shift. 3. The Administrator or designee will dit the facility mail delivery 3-5 times weekly for four weeks then; weekly months to ensure timely mail deliver. The results of these audits will be tato the monthly QAPI Committee Me for further review and recommendation for continuing or discontinuing the accommendation.	y and iewed ided aff policy will be ieir	
LABORATORY	DIRECTOR'S OR PROVIDER!S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
_ 10010110111							2/24/2022

Kayla Evans

Executive Director

3/31/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (*) See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. In deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID ES2S11

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Facility ID: 0108

If continuation sheet Page 1 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED			
435118			B, WING			03/09/2022		
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385	ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 576	reasonable access to electronic communication video communication (i) If the access is ava (ii) At the resident's expense is incurred by access to the resident (iii) Such use must colaw. This REQUIREMENT by: Surveyor: 43021 Based on interview a provider failed to deliver a provider failed to delive a provider a failed to delive a provider a failed to delive a provider a failed to a failed a	sident has the right to have and privacy in their use of ations such as email and and for internet research. Allable to the facility expense, if any additional by the facility to provide such to the facility with State and Federal is not met as evidenced and policy review, the ever mail daily to ten of ten 14, 16, 21, 22, 28, and 33) curs after it was delivered to findings include:	F	576				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
435118			B. WING_			03/09/2022		
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP COL 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385	Œ			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 576	mail was picked up at weekdays. *She worked Monday *She could not confirm Saturdays. *She did confirm daily happened, including *She needed to work delivery. Review of the provide	post office. e days would pass before nd delivered during the r through Friday. m mail delivery on r mail delivery had not on Saturday. on the problem with mail er's 2015 Resident Mail goes to the resident within	F	576				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2022 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION NG	COMPLETED
		435118	B. WING_		03/09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		UTED		401 SOUTH FIRST AVENUE	
PRAIRIE \	VIEW HEALTHCARE CE	NIEK		WOONSOCKET, SD 57385	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID PREFI	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	HOULD BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE DATE	
E 000	Initial Comments		E	000	
	Surveyor: 06365 A recertification surve CER Part 482, Subpa	ey for compliance with 42 art B, Subsection 483.73,			
	Emergency Prepared Term Care Facilities,	dness, requirements for Long was conducted from 3/7/22 ie View Healthcare Center			
	was found in complia				
LABORATORY	 Y DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
Kavla	Fvans			Executive Direct	
Any deficienc	cy statement ending with an			ay be excused from correcting providing it is de ling homes, the findings stated above are disclo	
				the above findings and plans of correction are of ed, an approved plan of correction is requisite t	

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

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Event ID: ES2\$11

Facility ID: 0108

If continuation sheet Page 1 of 1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PRAIRIE VIEW CARE CENTER			(X3) DATE SURVEY COMPLETED	
		435118	B. WING			03/09/2022	
NAME OF F	NAME OF PROVIDER OR SUPPLIER			- 5	STREET ADDRESS, CITY, STATE, ZIP CODE		70072022
10.000	NOVIDEN ON OUT FIELD				101 SOUTH FIRST AVENUE		
PRAIRIE VIEW HEALTHCARE CENTER							
					WOONSOCKET, SD 57385		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
	Life Safety Code (LSC occupancy) was cond View Healthcare Cent	FR 483.90 (a) requirements					
	2012 LSC for existing upon correction of def	the requirements of the health care occupancies iciency identified at K321 in rovider's commitment to with the fire safety					
	having 1-hour fire resi fire rated doors) or an system in accordance When the approved at system option is used separated from other s partitions and doors in Doors shall be self-clo and permitted to have protective plates that of from the bottom of the Describe the floor and	protected by a fire barrier stance rating (with 3/4 hour automatic fire extinguishing with 8.7.1 or 19.3.5.9. utomatic fire extinguishing, the areas shall be spaces by smoke resisting accordance with 8.4. sing or automatic-closing nonrated or field-applied do not exceed 48 inches door. zone locations of are deficient in REMARKS.	К 3	21	1. The door to the Maintenance Offi was repaired so it properly latches with force of the automatic door close All residents were potentially at risk. 2. The Maintenance Director and Extive Director will ensure all facility do with automatic closures properly late der the force of the automatic closure. 3. The Maintenance Director or desiwill audit to ensure all doors with au matic closures are properly latching weekly for 4 weeks; then monthly for months. Audit findings will be discus by the Maintenance Director in mon QAPI meetings for review and recommendations on the continuation/discustion of the audit and any additionation required.	with ure. kecu- bors ch un- re. ignee to- br two ssed thly m- contin-	3/31/2022
ABORATORY	DIRECTOR'S OR PROVIDER/SI	JPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Kayla Evans

Executive Director

3/31/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction as provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. 3 1 2022

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ES2S21

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Facility ID: 0108

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PRAIRIE VIEW CARE CENTER			(X3) DATE SURVEY COMPLETED	
		435118	B. WING				03/09/2022
NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW HEALTHCARE CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE WOONSOCKET, SD 57385		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 321	e. Trash Collection R (exceeding 64 gallon f. Combustible Stora (over 50 square feet) g. Laboratories (if cla Hazard - see K322) This REQUIREMEN' by: Surveyor: 27198 Based on observatio provider failed to ma (boiler room/mainten Findings include: 1. Observation and t revealed the door to office was a fire rate automatic closer. Th latch to control acces that door revealed th the power of require feature. Interview with the dir time of the observatio The deficiency affect	han 100 square feet) ce, and Paint Shops ns (exceeding 64 gallons) nooms s) ge Rooms/Spaces assified as Severe T is not met as evidenced n, testing, and interview the intain one hazardous area ance office) as required. esting on 3/9/22 at 1:52 p.m. the boiler room/maintenance door provided with an at door had an electronic as into the room. Testing of the latch did not engage under do automatic self-closing rector of maintenance at the on confirmed that finding.	K	32			

South Dakota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: B. WING 03/09/2022 10714 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 401 S 1ST AVE POST OFFICE BOX 68 PRAIRIE VIEW HEALTHCARE CENTER WOONSOCKET, SD 57385 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73. Nursing Facilities, was conducted from 3/7/22 through 3/9/22. Prairie View Healthcare Center was found not in compliance with the following requirement(s): S408. 1, The clinical sink in the South Soiled 3/31/2022 S 408 S 408 44:73:12:09(1-15) Service Area in Care Units Utility Room was repaired. All residents were potentially at risk. Each care unit must shall contain a service area which includes the following: 2. The Maintenance Director and Execu-(1) Staff station with convenient access to tive Director will ensure all clinical sinks handwashing facilities; throughout the facility are properly func-(2) Staff charting; tioning. (3) Communications; (4) Storage for supplies and staff personal 3. The Maintenance Director or designee effects; will audit to ensure all clinical sinks (5) Staff toilet room; throughout the facility are properly func-(6) Nurses' office; tioning monthly for 3 months. Audit find-(7) Clean workroom for the storage and assembly ings will be discussed by the Mainteof supplies for nursing procedures which contains nance Director in monthly QAPI meeta work counter and sink: ings for review and recommendations on (8) Soiled workroom which contains a work the continuation/discontinuation of the counter with a handwashing facility, a waste audit and any further action required. receptacle, soiled linen receptacles, a clinical sink with an exposed water trap seal, siphon jet or blowout action, and a bedpan flushing device; (9) Medicine room adjacent to the staff station with a sink, refrigerator, locked storage, and facilities for preparation and administration of medication; (10) Clean linen storage area in an enclosed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(11) Nourishment station containing refrigerated storage, self-dispensing ice machine, and a sink for serving between-meal nourishments; (12) Equipment storage room on each resident wing or floor for storage of resident care

TITLE

(X6) DATE

Kayla Evans

storage space;

L., 6899

Executive Director

3/31/2022

MAR 3 1 2022

FK7L11

STATE FORM

If continuation sheet 1 of 3

South Dakota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: _ B. WING 03/09/2022 10714 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 401 S 1ST AVE POST OFFICE BOX 68 PRAIRIE VIEW HEALTHCARE CENTER WOONSOCKET, SD 57385 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 408 S 408 Continued From page 1 equipment; (13) Resident bathing facilities containing one shower, bathtub, or whirlpool for each 15 beds not individually served. Whirlpool units with lifts may serve 30 beds: (14) Janitor's closet for storage of housekeeping supplies and equipment which contains a floor receptor or service sink. The janitor's closet space and equipment may be incorporated into the soiled utility room; (15) Multipurpose rooms for staff, residents, and residents' families for conferences, reports, education, training sessions, and consultation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, and interview the provider failed to furnish every care unit with a clinical sink as required. Findings include: 1. Observation and interview on 3/9/22 at 12:02 p.m. revealed a clinical sink in the soiled utility room of the south win care unit. That clinical sink had a cover over it and an "out of order DO NOT use" sign on it. Not having a functioning clinical sink in that care unit does not meet the requirements for the care unit. Interview with the administrator at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for care units. S 000 S 000 Compliance/Noncompliance Statement Surveyor: 06365

FK7L11

South Dakota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 03/09/2022 B. WING 10714 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 401 S 1ST AVE POST OFFICE BOX 68 PRAIRIE VIEW HEALTHCARE CENTER WOONSOCKET, SD 57385 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Continued From page 2 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/7/22 through 3/9/22. Prairie View Healthcare Center was found in compliance.